Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COMBINED CHIROPRACTIC SERVICES &
REHABILITATION, INC
88 BRIGGS AVENUE SUITE 245
SAN ANTONIO TX 78224

Respondent Name
COMMERCE & INDUSTRY INSURANCE

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-11-2498-01

MFDR Date Received
MARCH 21, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "***Included you will find all HICFs' and proper documentation along Certification and/or License that Dr. Cary Davis DC is Licensed Practitioner To Perform This Test In The Worker Compensation Systems In The State of Texas. The patient was referred from his treating doctor Douglas W. Burke DC to Dr Cary Davis DC to have the test performed. The patient is approved for surgery and to oversee the approval the EMG-NCV was needed and medical necessity was established by the treating doctor****. The criteria were med according to the **EMG-NCV OGD GUIDELINES** and there are no grounds for the denial*."

Amount in Dispute: $2,165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier did not reimburse the $2,165.00 billed for the above date of service because the service is nerve conduction velocity testing performed by Carey Davis, D.C. and doctors of chiropractic are not permitted to perform this testing in the State of Texas."

Response Submitted By: Chartis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 24, 2010	CPT Code 95900-59 (x6)	$690.00	$0.00
	CPT Code 95903-59 (x4)	$460.00	$366.05
	CPT Code 95904-59 (x6)	$690.00	$411.90
	CPT Code 95861	$250.00	$0.00
	HCPCS Code A4556 (x6)	$30.00	$0.00
	HCPCS Code A4215	$5.00	$0.00

September 24, 2010	HCPCS Code A4558	$5.00	$0.00
	CPT Code 99211-25	$35.00	$27.71
TOTAL		$2,165.00	$805.66

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, *33 Texas Register 3954*, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. 22 Texas Administrative Code §75, effective December 24, 2009, *34 Texas Register 9208*, sets out the scope of practice for chiropractors.
4. District Court of Travis County, 250th Judicial District No. D-1-N-GN-06-003451, Honorable Stephen Yelenosky, Judge Presiding, Order on cross-motions for partial summary judgment dated November 24, 2009.
5. Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Opinion dated April 5, 2012.
6. Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Mandate dated August 8, 2013.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 185-The rendering provider is not eligible to perform the service billed.
- W1-Workers compensation state fee schedule adjustment.
- VH04-Service does not fall within the scope of the providers practice.
- VA07-This service/supply is not covered according to the state fee schedule guideline.
- Z306-Signingicat, separately identifiable evaluation and management service by the same Physician on the day of a procedure.
- X394-Our position remains the same if you disagree with our decision please contact the TWCC Medical Dispute Resolution
- Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.
- 18-Duplicatre claim/service.
- U301-This item was previously submitted and reviewed with notification of decision issued to payor, provider (duplicate invoice).

Litigation Background for Needle EMG and MUA

Portions of the Texas Board of Chiropractic Examiners rules of practice were challenged by the Texas Medical Association and the Texas Medical Board in 2009. At issue was whether 22 Texas Administrative Code §75.17(a)(3), (c)(2)(D), (c)(3)(A), and (e)(2)(O) were within the scope of chiropractic practice in Texas. Specifically, the parties sought judgment on whether rules allowing Chiropractors to perform needle electromyography (EMG) and manipulation under anesthesia (MUA) were valid. On November 24, 2009, the 345th District Court issued a judgment in which presiding judge Honorable Stephen Yelenosky concluded that needle EMG and MUA exceeded the statutory scope of chiropractic practice in Texas. The Texas Board of Chiropractic Examiners appealed the district court's judgment to the Texas Court of Appeals, Third District. The Texas Court of Appeals in *Tex. Bd. Of Chiropractic Examiners v. Tex. Med. Ass'n*., 375 S.W.3d 464 (Tex. App. – Austin, 2012, pet. den.) issued an opinion affirming the district court's judgment, and concluding that needle EMG and MUA services are not within the chiropractic scope-of-practice. The Chiropractic Board exhausted its appeals and on August 8, 2013, the mandate affirming the district court's judgment was issued. The mandate states "…we affirm the remainder of the district court's judgment that subparts 75.17(a)(3), (c)(2)(D), (c)(3)(A), and (e)(2)(O) of the Texas Board of Chiropractic Examiners' scope-of-practice rule are void." In accordance with the Texas Court of Appeals opinion, the final mandate, and the scope of chiropractic practice requirement in 28 Texas Administrative Code §134.203(a)(6), needle EMG and MUA services may not be reimbursed.

Issues

1. Is the rendering provider eligible to perform needle electromyography?

2. Is the rendering provider eligible to perform office visits?
3. Is the rendering provider eligible to perform nerve conduction tests?
4. Is the requestor entitled to reimbursement for CPT code 95900?
5. Is the requestor entitled to reimbursement for CPT code 99211, 95934, 95903, and 95904?
6. Is the requestor entitled to reimbursement for HCPCS codes A4556, A4215, and A4558?

Findings

1. CPT code 95861 is defined as "Needle electromyography; 2 extremities with or without related paraspinal areas." According to the medical documentation found, this service was performed by Cary Davis, D.C. (Doctor of Chiropractic). The Texas Court of Appeals in *Tex. Bd. Of Chiropractic Examiners v. Tex. Med. Ass'n*., 375 S.W.3d 464 (Tex. App. – Austin, 2012, pet. den.) issued an opinion affirming the district court's judgment, and concluding that needle EMG and MUA services are not within the chiropractic scope-of-practice of chiropractors. 28 Texas Administrative Code §134.203(a)(6) states "Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act." The division finds that disputed service code 95861 is not within the scope of chiropractic practice because it is an electro-diagnostic test that involves the insertion of a needle into the patient. Therefore, no reimbursement can be recommended for CPT code 95861 pursuant to 28 Texas Administrative Code §134.203(a)(6).
2. According to the explanation of benefits, the respondent denied reimbursement for the disputed office visit based upon reason codes "185 and VH04."
3. CPT code 99211 is defined as "Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services."

   The Division finds that the suit referenced above did not address office visits; therefore, per 28 Texas Administrative Code §134.203(a)(6) office visits are within the scope of chiropractic practice; therefore, the respondent's denial based upon reason codes "185 and VH04" are not supported.
4. Disputed services 95900, 95903, and 95904 fall in the category of nerve conduction tests under applicable AMA current procedural terminology (CPT). These tests involve placing a stimulating electrode is directly over the nerve to be tested. These are surface tests that do not involve needles. According to the medical documentation found, these services were performed by Cary Davis, D.C. (Doctor of Chiropractic). As stated in the Texas Court of Appeals, Third District at Austin, NO. 03-10-00673-CV, Opinion dated April 5, 2012

   > In the second provision, paragraph(c)(3)(A), TBCE imposed certification and supervision requirements on any licenses who administered "electro-neuro diagnostic testing" that varied according to whether the testing was "surface (non-needle)" or involved the use of needles. The import or effect of paragraphs (c)(2)(D) and (c)(3)(A), as the parties agree, was that chiropractors with specified training and certification could utilize needle EMG in evaluating or examining patients. In their live petitions and summary-judgment motions, the Physician Parties challenged the validity of the two rule provisions **specifically addressing needle EMG** [emphasis added]- 75.17(c)(2)(D) and (c)(3)(A) – plus the general standard regarding use of needles-75.17(a)(3)."

   That is, surface tests were not in question during this suit. Pursuant to §75.17(c)(3)(A) effective December 24, 2009, *34 Texas Register 9208*, services 95903, and 95904 are within the scope of chiropractic practice because they are surface tests. Reimbursement is recommended for these services.
5. 28 Texas Administrative Code §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Per The National Correct Coding Initiative Policy Manual "The NCCI edit with column one CPT code 95903 (Motor nerve conduction studies with F-wave study, each nerve) and column two CPT code 95900 (Motor nerve conduction studies without F-wave study, each nerve) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 95900 of this NCCI edit is appropriate only if the two procedures are performed on different nerves or at separate patient encounters." The requestor utilized modifier 59 to indicate that CPT code 95900 was a separate procedure. A review of the submitted report, does not support that motor testing nerves were different than the F-Wave study nerves or a separate patient encounter; therefore, reimbursement is not recommended.

6. Because these studies and evaluation, CPT codes 99211, 95903, and 95904, are within the scope of chiropractic practice reimbursement is recommended in accordance with 28 Texas Administrative Code §134.203(c).

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2010 DWC conversion factor for this service is 54.832.

   The Medicare Conversion Factor is 36.8729

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 78224, which is located in San Antonio, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for San Antonio, Texas.

   Using the above formula, the Division finds the following:

Code	Calculation for Locality 0440299 Rest of TX	Maximum Allowable
99211	(54.32/36.8729) x $18.81 for 1 Unit	$27.71
95903	(54.32/36.8729) x $62.12 for 4 Units	$366.05
95904	(54.32/36.8729) x $46.60 for 6 Units	$411.90
		$805.66

7. The requestor is seeking dispute resolution for HCPCS codes A4215, A4558, and A4556. According to Medicare policy "For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable)." A review of the submitted documentation finds that the requestor did not document the items billed under HCPCS codes A4215, A4558, and A4556, as a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due for the specified services. As a result, the amount ordered is $805.66.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $805.66 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		9/13/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.